

7338

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 FilmG265 6-24-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) --		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Louise Middle L. Last Bacon		4. DATE OF DEATH Month June 17, Year 19 60	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Miles		14. MOTHER'S MAIDEN NAME Harriett Cottman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Moses Bacon, Sr. - Princess Anne, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO (b) (Died in her sleep) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH instant			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. H. Johnson, M.D.		DATE SIGNED 6/21/60	
EXAMINER'S NAME (Type) R. H. Johnson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/21/60	22c. NAME OF CEMETERY OR CREMATORY Cottage Grove Cemetery	22d. LOCATION (City, town, or county) (State) RFD - Westover, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones		24. REC'D BY REGISTRAR JUN 22 '60	
ADDRESS Princess Anne, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7339

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. LENGTH OF STAY IN 1b <u>64 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u> X	
3. NAME OF DECEASED (Type or print) <u>Percy Joseph Bell</u>		d. STREET ADDRESS <u>Marion Sta. P.O. #96</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood worker</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
12. BIRTHPLACE (State or foreign country) <u>Marion Station</u>		13. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
14. FATHER'S NAME <u>Henry Bell</u>		15. MOTHER'S MAIDEN NAME <u>Mary Williams</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>6/19/18</u>		17. SOCIAL SECURITY NO. <u>214-03-5848</u>	
18. INFORMANT <u>Albert Bell</u>		19. ADDRESS <u>Marion Sta., Md. #96</u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural Cause - Heart Complaint</u> <u>775.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Indigestion Wife went down</u> (c) <u>Stair to medicine when returned</u> cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>he was dead</u>		INTERVAL BETWEEN ONSET AND DEATH	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, if any, or of lesion.) <u>William H. Coulbourn, M. D.</u>	
22a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		22b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
23a. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) <u>FOR SOMERSET COUNTY, MD.</u>		23b. (City or town) (County) (State)	
24. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wm H Coulbourn</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 3-1960</u>	
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		25b. DATE THEREOF <u>6/5/60</u>	
25c. NAME OF CEMETERY OR CREMATORY <u>Branch</u>		25d. LOCATION (City, town, or county) (State) <u>Marion Sta., Md. #235</u>	
26. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u>		ADDRESS <u>Marion Sta., Md. #235</u>	
27a. REC'D BY REGISTRAR <u>DATE JUN 7 '60</u>		27b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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[illegible]

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54324, 54325

1957-1958 6-10-58.

Henry Bell

1992

1972

2292

1138

14. 203171 10/5/61.

revised finally

small white

24-02-2004 11:11 AM

10/15/2010 10:10 AM

Chlorophyll  $a$  and  $b$  were determined by the method of Arar and Collins (1971).

## 7340 CERTIFICATE OF DEATH

Reg. Dist. No. 07320

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		e. STREET ADDRESS <b>MYRTLE</b>	
3. NAME OF DECEASED (Type or print) First <b>CYNTHIA</b> Middle <b>ANN</b> Last <b>DANIELS</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MAY 14, 1902</b>
9. AGE (In years lost birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>5</b> Days <b>10</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>TENNESSEE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARION ALLEN</b>		14. MOTHER'S MAIDEN NAME <b>LATHA LYLES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>420-20-3609</b>	
17. INFORMANT <b>GERALDINE WARD, CRISFIELD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>157X</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>myocardial deterioration</b> (c) <b>carcinoma of pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>30 Oct. 1960</b> to <b>23 June 1960</b> that I last saw the deceased alive on <b>22 June 1960</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert W. Ireland</b> M.D.		ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED <b>28 June 60</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT W. IRELAND, M.D.,</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 26, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Asbury ME Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Crisfield, Maryland</b>		(State)	
23. BURIAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JUL 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1947

UNITED STATES OF AMERICA



CERTIFICATE OF DEATH

Reg. Dist. No.

07321

7341

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNIE DIZE</b>		4. DATE OF DEATH Month Day Year <b>JUNE 9 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-20-1871</b>
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK MESSICK</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES NORTH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT Address <b>MILLIE DIZE, CRISFIELD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage -</b> DUE TO <b>Gen'l Arteriosclerosis -</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) <b>Gen'l Arteriosclerosis -</b> DUE TO (c) <b>Gen'l Arteriosclerosis -</b>			INTERVAL BETWEEN ONSET OF DEATH <b>20 hrs -</b> <b>year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1947</b> to <b>June 9, 1960</b> that I last saw the deceased alive on <b>June 9, 1960</b> and that death occurred at <b>3:20 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D.		ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-11-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CRISFIELD</b>	22d. LOCATION (City, town, or county) (State) <b>CRISFIELD - MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. S. Webster</b> ADDRESS <b>CRISFIELD</b>		24a. REC'D BY REGISTRAR <b>JUN 16 60</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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432

1992-1993

2005-06-01 14:00



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-issued by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07322

7342

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. LENGTH OF STAY IN 1b <b>16 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>E.W. MCCREADY MEMO HOSPITAL</b>				e. STREET ADDRESS <b>Rt. 1, Marion Station</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>BELL</b> Last <b>DRYDEN</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 15, 1878</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>REHOBETH, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Bell</b>				14. MOTHER'S MAIDEN NAME <b>Anna Brittingham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>NORRIS DRYDEN 48 BEECHWOOD ST P.A.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Cereb. Dis. 7 xant. Urine</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Chronic myocardial disease at age 82</b> DUE TO (c) <b>Yes</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 21</b> , 19 <b>60</b> , to <b>June 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6-5</b> , 19 <b>60</b> , and that death occurred at <b>6:55 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.				ADDRESS (Street, city or town, state) <b>MARION, Md.</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN</b>				<b>MARION, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rehobeth Methodist Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Rehobeth, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

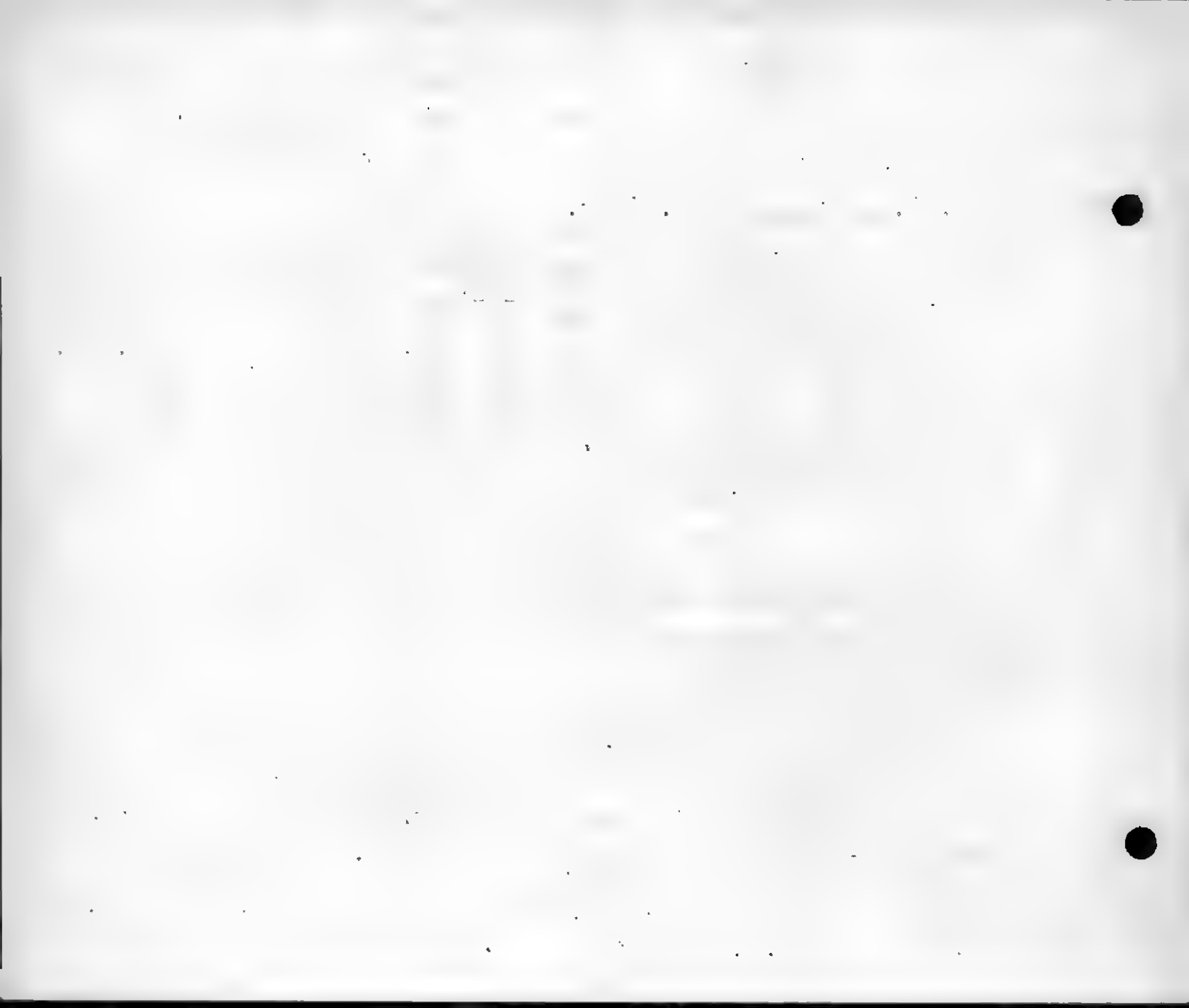
1934  
CONTINUED TO PAGE 10  
[Faint, mostly illegible text follows, appearing to be a continuation of a document or report. The text is mirrored across the page, suggesting a bleed-through effect.]

## CERTIFICATE OF DEATH

Reg. Dist. **07323**

7343

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>20 CRISFIELD</b> d. STREET ADDRESS <b>ASBURY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANGIE</b> Middle <b>GOULD</b> Last <b>GOULD</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-6-1868</b>
9. AGE (In years last birthday) <b>91</b>		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY DIZE</b>		14. MOTHER'S MAIDEN NAME <b>JULIANA EVANS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>GEORGE NORTH,</b>		Address <b>CRISFIELD, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Hip</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 17, 1960</b> to <b>June 19, 1960</b> , that I last saw the deceased alive on <b>June 19, 1960</b> , and that death occurred at <b>4:07 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED <b>4/20/60</b>			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.		PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>BURIAL</b>		<b>9/21/60</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>SUNNYBRIDGE</b>		<b>HOPEWELL MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. S. WILSTER</b>		ADDRESS <b>CRISFIELD MD</b>	
DATE <b>JUN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

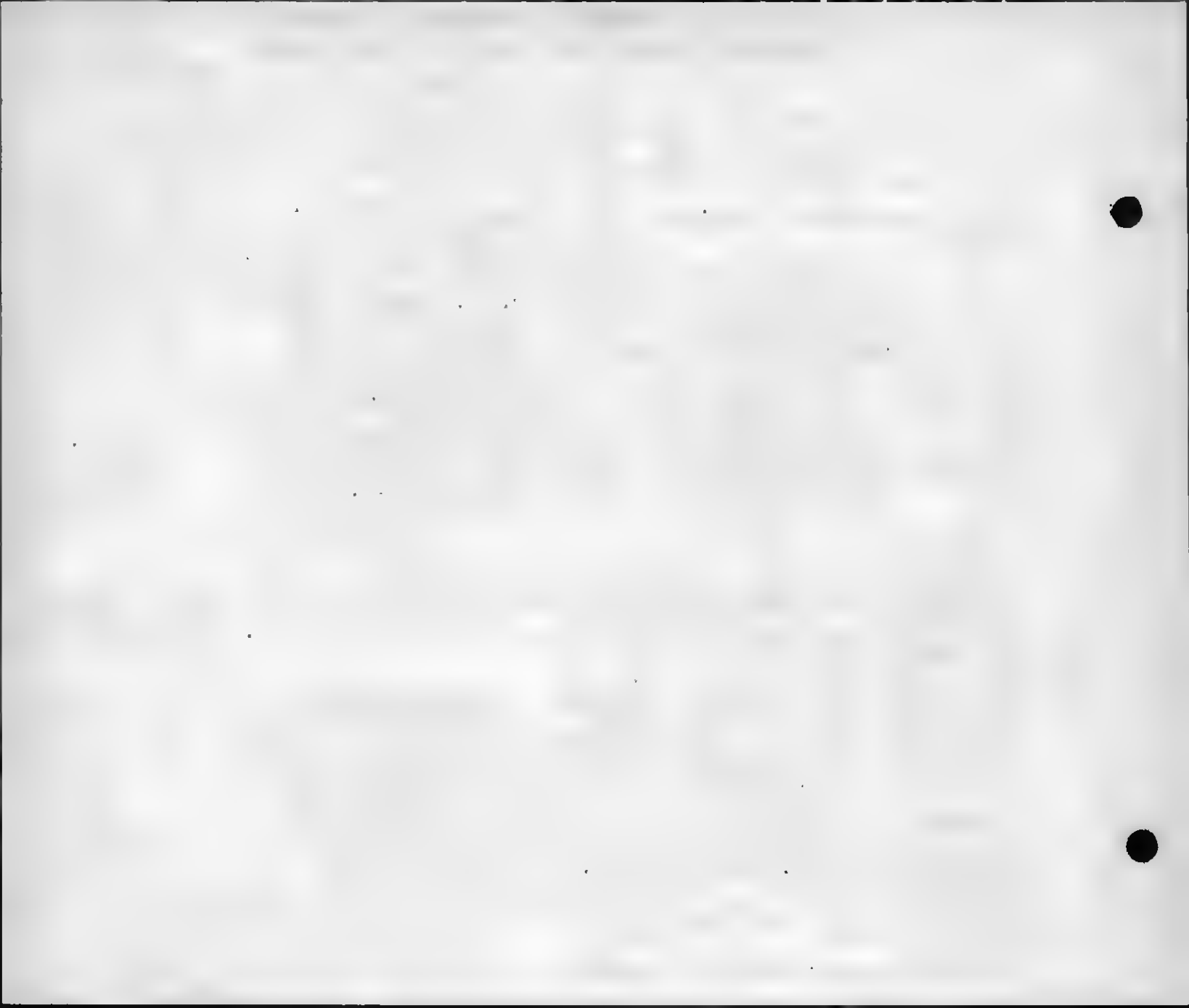
07324

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>50 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>15 Collins St.</b>				e. STREET ADDRESS <b>15 Collins St.</b>			
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>WATERS</b> Last <b>HOLLAND</b>				4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 25, 1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crab Picker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Mullens Waters</b>				14. MOTHER'S MAIDEN NAME <b>Laura Waters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-01-6660</b>		17. INFORMANT <b>Mary Waters, 1026 Edmondson, Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>Subject fell dead while dusting table in living room of home.</b>				IF WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William H. Coulbourn</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M. D.</b>				DATE SIGNED <b>6/9/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 10, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Centennial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Fairmount, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

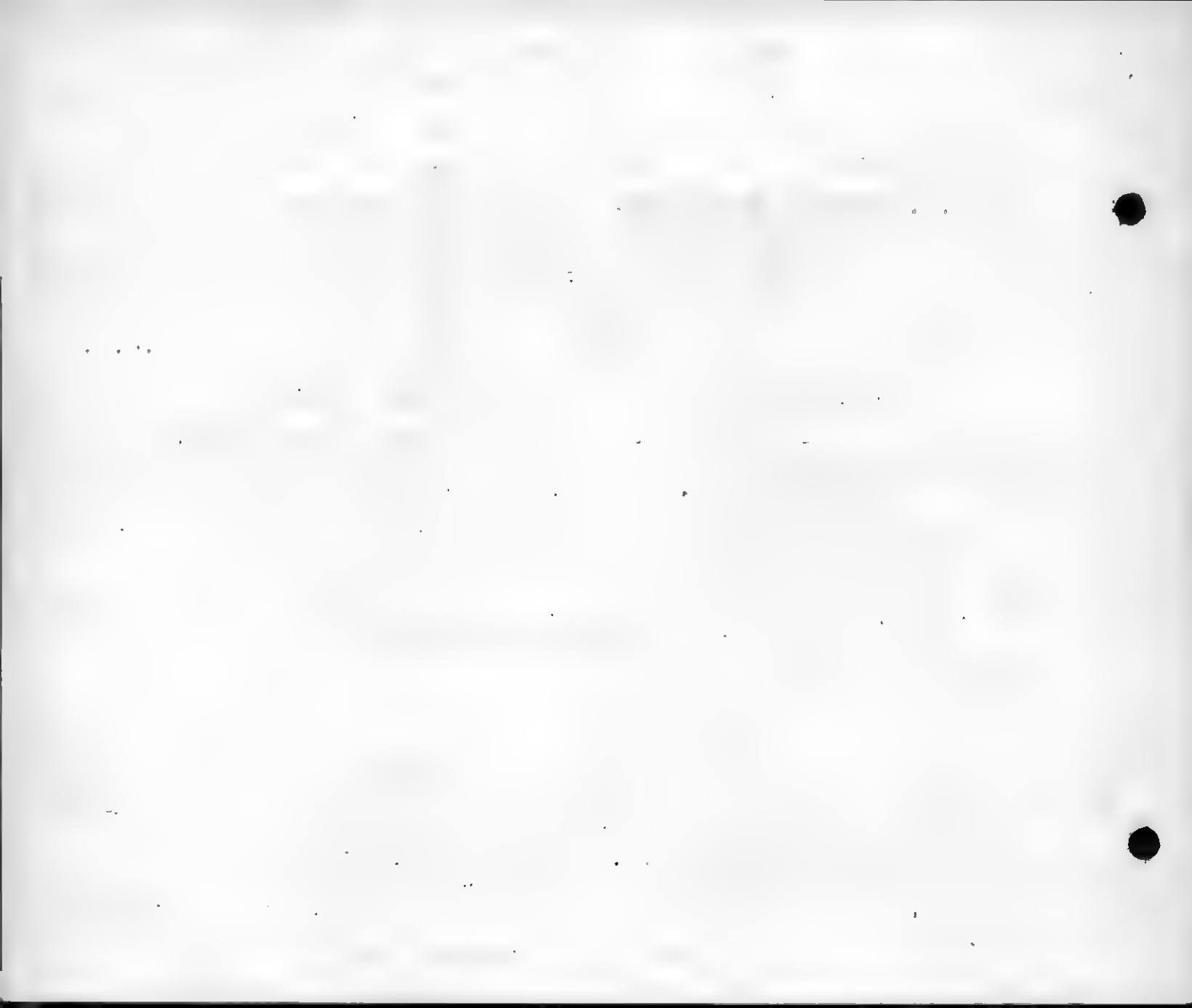
7344

## CERTIFICATE OF DEATH

Reg. Dist. No. 07325

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b> c. LENGTH OF STAY IN lb <b>10 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO HOSP.</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-MARION STATION</b> d. STREET ADDRESS <b>RFD 1 Box 142</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>M.</b> Last <b>RIGGIN</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 11, 1874</b>	
9. AGE (In years last birthday) <b>86</b>		10. AGE (In years last birthday) <b>86</b>		11. IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min <b>12</b>		12. IF UNDER 24 HRS. Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>GEORGE RIGGIN</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE MATTHEWS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>---</b>			
17. INFORMANT <b>EVERETT GRAY, SHELLTOWN, MARYLAND</b>				Address <b>---</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>1. Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>2. Hypertension</b> DUE TO <b>3. Atherosclerosis</b> DUE TO <b>4. Diabetes Mellitus</b> DUE TO <b>5. Coronary Artery Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Trauma - Injury by car 10 days</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/24</b> , 19 <b>60</b> , to <b>6/1</b> , 19 <b>60</b> that I last saw the deceased alive on <b>5/31</b> , 19 <b>60</b> , and that death occurred at <b>7:00AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED <b>6-1-60</b>							
ACTUAL SIGNATURE <b>A. N. BARR, M.D.</b> M.D. <b>CRISFIELD, MARYLAND</b>							
PHYSICIAN'S NAME (Type) <b>A. N. BARR, M.D.</b> <b>CRISFIELD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 5, 1960</b>		22c. NAME OF CEMETERY <b>Rehoboth Baptist</b>		22d. LOCATION (City, town, or county) (State) <b>Rehoboth Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Vane</b> ADDRESS <b>Pocomoke City, Md.</b>							
24a. REC'D BY REGISTRAR <b>JUN 6 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

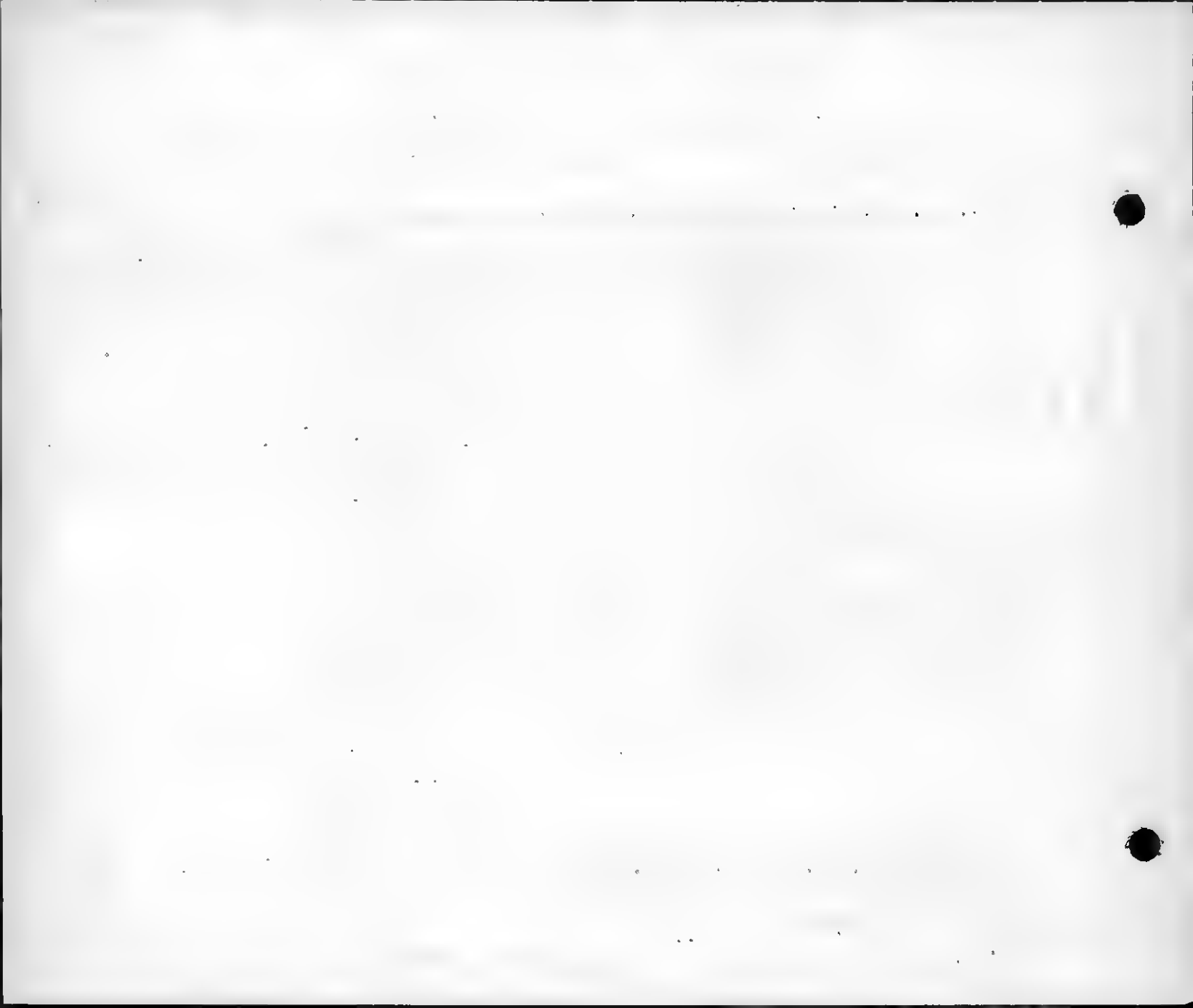
Reg. Dist. No.

07326

7345

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ORIOLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREARY MEMORIAL HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edith</b> First <b>Edith</b> Middle <b>Smith</b> Last <b>Smith</b>				4. DATE OF DEATH <b>JUNE</b> Month <b>11</b> Day <b>1960</b> Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 8, 1877</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM TYLER</b>				14. MOTHER'S MAIDEN NAME <b>JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO <b>INFORMANT</b> <b>GERTRUDE EVANS, CRISFIELD, MARYLAND</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary thromboses</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>June 10, 1960</b> , to <b>June 11, 1960</b> that I last saw the deceased alive on <b>June 11, 1960</b> , and that death occurred at <b>2:35 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>C. G. Rawley</b> M.D. PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.</b> <b>CRISFIELD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/13/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oriole</b>		22d. LOCATION (City, town, or county) (State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Leman</b>				24a. REC'D BY REGISTRAR <b>JUN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7337  
CERTIFICATE OF DEATH

Reg. Dist. No.

07327

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>	
c. LENGTH OF STAY IN 1b <u>LIFETIME</u>		d. STREET ADDRESS <u>1 LAWSONIA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HER LATE HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY</u> <u>CRISSIE</u> <u>STERLING</u>		4. DATE OF DEATH Month Day Year <u>JUNE 12</u> <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 7-1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD DUTIES</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-SA</u>	
13. FATHER'S NAME <u>WILLIAM</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE SEARS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1-20</u>	
17. INFORMANT <u>KENNETH</u>		Address <u>STERLING - CRISFIELD MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral - Coronary Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 1957</u> , to <u>June 12, 1960</u> , that I last saw the deceased alive on <u>June 12, 1960</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D.		ADDRESS (Street, city or town, state) <u>33 W. Main Street Crisfield</u>	
PHYSICIAN'S NAME (Type) <u>SARAH M. PEYTON</u>		DATE SIGNED <u>6/15/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JUNE 15, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ASHBURY METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>CRISFIELD MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. B. Webster</u>		ADDRESS <u>Crisfield Md</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7346

CERTIFICATE OF DEATH

Reg. Dist. No. 07328

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperhill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperhill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Norman E. Waters</u>		4. DATE OF DEATH <u>June 17 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1889</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR <u>12</u> Months <u>17</u> Days <u>19</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Upperhill Som.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Waters</u>		14. MOTHER'S MAIDEN NAME <u>Marcelena Beckett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-34-7428A</u>	
17. INFORMANT <u>Jessie Waters</u>		Address <u>Upperhill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Generalized atherosclerosis</u> DUE TO (c) <u>Essential Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>4 yrs.</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/51</u> , 19 <u>51</u> , to <u>6/16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/16/60</u> , 19 <u>60</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bevil A. Juveney</u> M.D.		ADDRESS (Street, city or town, state) <u>801 - 4th St., Besenoke</u> DATE SIGNED <u>6/17/60</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Ward - Marion St., Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 22, 60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Waters</u>	22d. LOCATION (City, town, or county) (State) <u>Upperhill, Som. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion St., Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 24 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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IN WITNESS WHEREOF

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07329

7347

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HIS HOME</u>		e. STREET ADDRESS <u>MAIN ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>PRESTON</u> Middle <u>SILAS</u> Last <u>WEBSTER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 2 - 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL WEBSTER</u>		14. MOTHER'S MAIDEN NAME <u>JULIA HORNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-16-3517</u>	
17. INFORMANT <u>BEATRICE WEBSTER</u>		Address <u>DEAL ISLAND MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cancer of liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-19-56</u> , 19____, to <u>6-1-60</u> , 19____, that I last saw the deceased alive on <u>6-1-60</u> , 19____, and that death occurred at <u>2AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Dames Quarter, Maryland</u> DATE SIGNED <u>6/2/60</u> ACTUAL SIGNATURE <u>Everett C. Sutter MD</u> M.D. <u>Everett C. Sutter MD</u> PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/3/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHN'S METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>DEAL ISLAND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u> ADDRESS <u>Deal Island</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Thoma</u>			

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

1967



1. Name of Deceased		2. Sex		3. Race	
4. Date of Birth		5. Date of Death		6. Place of Birth	
7. Usual Residence		8. Cause of Death		9. Manner of Death	
10. Physician		11. Hospital		12. Burial Place	
13. Signature of Physician		14. Signature of Registrar		15. Date of Registration	
16. Signature of Medical Examiner		17. Signature of Coroner		18. Signature of Funeral Director	
19. Signature of Health Officer		20. Signature of County Health Officer		21. Signature of City Health Officer	
22. Signature of State Health Officer		23. Signature of State Registrar		24. Signature of State Coroner	
25. Signature of State Medical Examiner		26. Signature of State Funeral Director		27. Signature of State Burial Place	
28. Signature of State Health Officer		29. Signature of State Registrar		30. Signature of State Coroner	
31. Signature of State Medical Examiner		32. Signature of State Funeral Director		33. Signature of State Burial Place	
34. Signature of State Health Officer		35. Signature of State Registrar		36. Signature of State Coroner	
37. Signature of State Medical Examiner		38. Signature of State Funeral Director		39. Signature of State Burial Place	
40. Signature of State Health Officer		41. Signature of State Registrar		42. Signature of State Coroner	
43. Signature of State Medical Examiner		44. Signature of State Funeral Director		45. Signature of State Burial Place	
46. Signature of State Health Officer		47. Signature of State Registrar		48. Signature of State Coroner	
49. Signature of State Medical Examiner		50. Signature of State Funeral Director		51. Signature of State Burial Place	
52. Signature of State Health Officer		53. Signature of State Registrar		54. Signature of State Coroner	
55. Signature of State Medical Examiner		56. Signature of State Funeral Director		57. Signature of State Burial Place	
58. Signature of State Health Officer		59. Signature of State Registrar		60. Signature of State Coroner	
61. Signature of State Medical Examiner		62. Signature of State Funeral Director		63. Signature of State Burial Place	
64. Signature of State Health Officer		65. Signature of State Registrar		66. Signature of State Coroner	
67. Signature of State Medical Examiner		68. Signature of State Funeral Director		69. Signature of State Burial Place	
70. Signature of State Health Officer		71. Signature of State Registrar		72. Signature of State Coroner	
73. Signature of State Medical Examiner		74. Signature of State Funeral Director		75. Signature of State Burial Place	
76. Signature of State Health Officer		77. Signature of State Registrar		78. Signature of State Coroner	
79. Signature of State Medical Examiner		80. Signature of State Funeral Director		81. Signature of State Burial Place	
82. Signature of State Health Officer		83. Signature of State Registrar		84. Signature of State Coroner	
85. Signature of State Medical Examiner		86. Signature of State Funeral Director		87. Signature of State Burial Place	
88. Signature of State Health Officer		89. Signature of State Registrar		90. Signature of State Coroner	
91. Signature of State Medical Examiner		92. Signature of State Funeral Director		93. Signature of State Burial Place	
94. Signature of State Health Officer		95. Signature of State Registrar		96. Signature of State Coroner	
97. Signature of State Medical Examiner		98. Signature of State Funeral Director		99. Signature of State Burial Place	
100. Signature of State Health Officer		101. Signature of State Registrar		102. Signature of State Coroner	